

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2008
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

MY OWN PLACE

STREET ADDRESS, CITY, STATE, ZIP CODE

3215 20TH STREET, NE

WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>On December 2, 2008, at 4:50 PM the State Agency (SA) was notified, via telephone, by the Executive Director of the death of Client #1. According to the telephone interview with the director, Client #1 was transported to a local hospital emergency room on October 4, 2008 for "blacking out" while in the bathroom. The director further revealed that staff described Client #1's incident as "dropping back with her eyes rolled back." It was thought that it may have been a "new onset of seizures."</p> <p>Client #1 was admitted to the hospital for further evaluation, but at the time of the provider's internal investigation, (completed on October 10, 2008), a primary diagnoses had not been established. Client #1's health was noted to deteriorate quickly after her admission and it was determined that she was in need of extensive rehabilitation. Client #1 was discharged from the hospital and admitted into a local rehabilitation center. Two days after her discharge from the hospital, the client aspirated and was sent to another local hospital. While there, she was admitted and placed on a ventilator to aid with her breathing. According to the director, Client #1's health continued to deteriorate and her body functions began to shut down. On December 2, 2008, Client #1 was taken off of life support and died shortly after 4:00 PM.</p> <p>An on-site investigation was conducted by the SA on December 3, 2008, to verify compliance with federal regulatory requirements prior to Client #1's death. The results of the investigation were based on interviews with the facility's nursing and direct care staff and administrative personnel. Also the findings were based on the review of the</p>	W 000	<p>Received 12/26/08</p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER	12/03/2008
MY OWN PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYC011

Facility ID: 09G027

If continuation sheet Page 2 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2008
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

MY OWN PLACE

STREET ADDRESS, CITY, STATE, ZIP CODE

3215 20TH STREET, NE

WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	<p>Continued From page 2</p> <p>was admitted to the hospital and diagnosed with syncope (unknown etiology).</p> <p>Interview with the Registered Nurse (RN) and review of Client #1's medical record on December 3, 2008, revealed a monthly nursing assessment dated September 27, 2008. According to the note, in a section entitled, "Systems Review/Risk Assessment," a recommendation was made to follow-up with an "MRI of the brain and appointment with the neurologist." The RN indicated that when she started, in July 2008, she reviewed the client's medical record and discovered that the recommendation for Client #1 to receive the MRI had not been completed. Additionally, the monthly nursing assessment (dated September 27, 2008) recommended to "follow-up on any outstanding appointments, continue with current plan of care and report any changes to the nurse."</p> <p>Further interview with the RN and review of the client's medical record revealed that Client #1 had been seen initially by the neurologist on September 7, 2006. Review of the corresponding neurological consult revealed the client was referred to the specialist because she had experienced four seizure-like episodes. Further review of the consult revealed the direct care staff reported that the client was also experiencing urinary incontinence and visual hallucinations. The neurologist recommended an EEG and an MRI of the brain to rule-out any structural lesions. Client #1 was to return for a follow-up appointment after the completion of the MRI or in six weeks.</p> <p>On September 25, 2006, Client #1 was scheduled for the MRI, however, the MRI was not completed</p>	W 124	<p>W124</p> <p>The newly hired Registered Nurse failed to fully review the quarterly progress notes and recommendations; specifically those from the PCP dated 04.07.2008 (see attachment). The RN has received additional training to ensure that all new recommendations are reviewed and "signed off" by the RN. Follow up action will be completed as deemed necessary.</p> <p>Contract clinicians were in-serviced on 09.10.2008 on their responsibility to demonstrate that all recommendations have been reviewed. (See attachment). Random quarterly quality assurance reviews of medical records will be conducted by the Director of Health Services to monitor timely completion and follow-up of clinician recommendations.</p>	<p>04.07.08</p> <p>Ongoing</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2008
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

MY OWN PLACE

STREET ADDRESS, CITY, STATE, ZIP CODE

3215 20TH STREET, NE

WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	Continued From page 3 because the client would not hold her head still. Additionally, review of the consult revealed a recommendation was made for the client to be sedated. Continued review of the client's record revealed the client was also seen by the neurologist on March 6, 2007. The consultation form revealed the MRI was again not completed because the client was unable to remain still and follow instructions. Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on December 3, 2008, at 11:01 AM revealed Client #1 had a legal guardian that was involved in her care. According to the QMRP and record verification on December 3, 2008, the client was assigned a legal guardian on March 13, 2008. Continued interview with the QMRP revealed that she did not know if Client #1's legal guardian was made aware of the client's need for an MRI and EEG, including the recommended sedation. At the time of the survey, the facility failed to provide evidence that revealed Client #1's legal guardian had been informed of the client's medical condition (need for specialty testing, MRI with recommended sedation and EEG).	W 124		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	W148	W148 The provider will in-service staff on appropriate notification in the event of changes in the individuals condition, serious illness, accident, death abuse or unauthorized absence or any other unusual situation.	1/15/09

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2008
---	---	--	--

NAME OF PROVIDER OR SUPPLIER MY OWN PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 148	<p>Continued From page 4</p> <p>failed to ensure parents/guardians were notified of serious incidents, for Client #1.</p> <p>The finding includes:</p> <p>Review of the facility's incident reports on December 3, 2008, beginning at 8:51 AM revealed the following:</p> <p>On October 4, 2008, staff reported that Client #1 began to black out during her morning care in the facility's bathroom. The report revealed the client was transported to the emergency room via ambulance. Review of the internal investigation on the aforementioned date revealed the client was admitted to the hospital and diagnosed with syncope with an unknown etiology.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on December 3, 2008, at 11:01 AM revealed Client #1 had a legal guardian that was involved in her care. At the time of the survey, however, the facility failed to provide evidence that Client #1's guardian had been notified of the aforementioned incident.</p>	W148	<p>Continued from page 4</p> <p>W148</p> <p>Training will include who to contact and appropriate documentation. Additionally, updated information on the next of kin/guardian will be provided on the individual's health passport. The RN and QMRP will update the Health Passport annually and PRN to reflect accurate contact information.</p> <p>In addition, the IMC will review all reports to ensure all required parties are contacted in a timely manner.</p>	1/15/09
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for Client #1.</p>	W 159	<p>W159</p> <p>Reference response to W124</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 159	Continued From page 5 The finding includes: [Cross Refer to W331] The QMRP failed to coordinate services with the Interdisciplinary Team (IDT) to ensure that the recommendation to conduct a MRI of the brain (to rule out structural lesions) was addressed for Client #1.	W 159			
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure general and preventative care services was provided for one of one client (Client #1) being investigated. The findings include: Review of the facility's incident reports on December 3, 2008, beginning at 8:51 AM revealed an incident involving Client #1 dated October 4, 2008. According to the report, Client #1 began to black out in the facility's bathroom during her morning care. The report further revealed the client was transported to the emergency room via ambulance. Review of the internal investigation dated December 10, 2008, on December 3, 2008, revealed the client was admitted to the hospital and diagnosed with syncope (unknown etiology). Interview with the facility's Registered Nurse (RN) on December 3, 2008, was conducted to ascertain if Client #1 had experienced any medical concerns prior to her admission to the	W 322	W322 Reference response to W124		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 322	<p>Continued From page 6</p> <p>hospital on October 4, 2008. According to the RN, Client #1 had not experienced any medical problems before her admission to the hospital. Additionally, interview was conducted with a direct care staff on December 3, 2008 at 10:06 AM that further verified Client #1's health status (no medical concerns) prior to her admission to the hospital.</p> <p>Continued interview with the RN and review of Client #1's medical record on December 3, 2008, revealed a monthly nursing assessment dated September 27, 2008. Review of the nursing assessment revealed a page entitled "Systems Review/Risk Assessment." According to the Systems Review/Risk Assessment, a recommendation was made to follow-up with an "MRI of the brain and appointment with the neurologist." The RN indicated that when she started, in July 2008, she reviewed the client's medical record and discovered that the recommendation for Client #1 to receive the MRI had not been completed. Additionally, the monthly nursing assessment (dated September 27, 2008) recommended to "follow-up on any outstanding appointments, continue with current plan of care and report any changes to the nurse."</p> <p>Further interview with the RN and review of the client's medical record revealed that Client #1 had been seen initially by the neurologist on September 7, 2006. Review of the corresponding neurological consult revealed the client was referred to the specialist because she had experienced four seizure-like episodes. Further review of the consult revealed the direct care staff reported that the client was also experiencing urinary incontinence and visual hallucinations.</p>	W 322			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 322	Continued From page 7 The neurologist recommended an EEG and an MRI of the brain to rule-out any structural lesions. Client #1 was to return for a follow-up appointment after the completion of the MRI or in six weeks. On September 25, 2006, Client #1 was scheduled for the MRI, however, the MRI was not completed because the client would not hold her head still. Additionally, review of the consult revealed a recommendation was made for the client to be sedated. Continued review of the client's record revealed the client was also seen by the neurologist on March 6, 2007. The consultation form revealed the MRI was again not completed because the client was unable to remain still and follow instructions. At the time of the investigation, the facility failed to provide evidence that Client #1 received the recommended MRI and/or failed to provide evidence that the recommendation for the MRI was alternatively addressed.	W 322			
W 326	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure Client #1 received recommended specialty studies, including an MRI and an EEG. The finding includes: 1. The facility failed to provide evidence that Client #1 received a recommended MRI and/or failed to provide evidence that the	W 326	W326 1. Reference response to W124 Client #1 also underwent CT scan of the brain without contrast on 10/21/06 as further investigation of the diagnosis of altered mental state. (See attached report). Results of the CT scan revealed "no evidence of acute intracranial pathology".	4.7 08 10.21.06	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 326	<p>Continued From page 8</p> <p>recommendation for the MRI was alternatively addressed. (See W322)</p> <p>2. (Cross Refer to W322) Review of the facility's incident reports on December 3, 2008, beginning at 8:51 AM revealed an incident involving Client #1 dated October 4, 2008. According to the report, Client #1 began to black out in the facility's bathroom during her morning care. The report further revealed the client was transported to the emergency room via ambulance. Review of the internal investigation dated December 10, 2008, on December 3, 2008, revealed the client was admitted to the hospital and diagnosed with syncope (unknown etiology).</p> <p>Interview with the facility's Registered Nurse (RN) on December 3, 2008, was conducted to ascertain if Client #1 had experienced any medical concerns prior to her admission to the hospital on October 4, 2008. According to the RN, Client #1 had not experienced any medical problems before her admission to the hospital.</p> <p>Further interview with the facility's RN and review of Client #1's medical record on December 3, 2008, beginning at 12:49 PM was conducted to determine the client's health status prior to her death. The record revealed a monthly nursing assessment dated September 27, 2008. The assessment documented a recommendation to follow-up with an "MRI of the brain and appointment with the neurologist." The RN indicated that when she started, in July 2008, she reviewed the client's medical record and discovered that the recommendation for Client #1 to receive the MRI had not been completed. Additionally, the monthly nursing assessment (dated September 27, 2008) recommended to</p>	W 326	<p>W326</p> <p>2. Reference response to W124</p> <p>The EEG ordered by the neurologist was completed on 09/07/2006. The provider will ensure that specialty examinations and procedures are permanently maintained in the active medical record to ensure continuity of care. The provider will clearly indicate critical documents that are not to be purged from the active record. Purged records will be reviewed to ensure that critical documents remain in the active medical record. Nurses will receive additional training on the provider policy on maintenance of medical records, particularly as it pertains to purging medical records. (See attached)</p>	12/30/08	1/15/09

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 326	Continued From page 9 "follow-up on any outstanding appointments, continue with current plan of care and report any changes to the nurse." Continued interview with the RN and review of the client's medical record revealed that Client #1 had been seen initially by the neurologist on September 7, 2006. Review of the corresponding neurological consult revealed the client was referred to the specialist because she had experienced four seizure-like episodes. Further review of the consult revealed the direct care staff reported that the client was also experiencing urinary incontinence and visual hallucinations. The neurologist recommended an EEG and an MRI of the brain to rule-out any structural lesions. Additional review of Client #1's record on December 3, 2008, revealed a physician's quarterly progress note dated July 2, 2007. The progress note indicated that Client #1 had an EEG in November 2006. The physician's progress note further documented that the EEG was completed. Interview with the RN on December 3, 2008, was conducted to ascertain information regarding the results of the EEG. The RN revealed the client's record had been purged. At the time of the investigation, the facility failed to provide evidence that verified the EEG had been conducted.	W 326			
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure nursing services were	W 331			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 331	<p>Continued From page 10 provided to make certain Client #1 received a recommended MRI and EEG.</p> <p>The finding includes :</p> <ol style="list-style-type: none"> 1. The facility nursing personnel failed to ensure Client #1 received an MRI as recommended. (See W322). 2. The facility nursing personnel failed to provide evidence that Client #1 received an EEG as recommended. (See W331). 	W 331	<p>W331</p> <ol style="list-style-type: none"> 1. Reference response to W124 2. Reference response to W326 		

PRINTED: 12/17/2008
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
1000	<p>INITIAL COMMENTS</p> <p>On December 2, 2008, at 4:50 PM the State Agency (SA) was notified, via telephone, by the Executive Director of the death of Resident #1. According to the telephone interview with the director, Resident #1 was transported to a local hospital emergency room on October 4, 2008 for "blacking out" while in the bathroom. The director further revealed that staff described Resident #1's incident as "dropping back with her eyes rolled back." It was thought that it may have been a "new onset of seizures."</p> <p>Resident #1 was admitted to the hospital for further evaluation, but at the time of the provider's internal investigation, (completed on October 10, 2008), a primary diagnoses had not been established. Resident #1's health was noted to deteriorate quickly after her admission and it was determined that she was in need of extensive rehabilitation. Resident #1 was discharged from the hospital and admitted into a local rehabilitation center. Two days after her discharge from the hospital, the resident aspirated and was sent to another local hospital. While there, she was admitted and placed on a ventilator to aid with her breathing. According to the director, Resident #1's health continued to deteriorate and her body functions began to shut down. On December 2, 2008, Resident #1 was taken off of life support and died shortly after 4:00 PM.</p> <p>An on-site investigation was conducted by the SA on December 3, 2008, to verify compliance with federal regulatory requirements prior to Resident #1's death. The results of the investigation were based on interviews with the facility's nursing and direct care staff and administrative personnel. Also the findings were based on the review of the</p>	1000			

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

PYC011

If continuation sheet 1 of 10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	Continued From page 1 client's habilitation, medical, and administrative records including incident reports.	I 000		
I 002	3500.2 GENERAL PROVISIONS Each GHMRP licensee and residence director shall demonstrate that he or she understands that the provisions of D.C. Law 2-137, D.C. Code, Title 6, Chapter 19 govern the care and rights of mentally retarded persons in addition to this chapter. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP licensee and residence director failed to demonstrate that he or she understood that the provisions of Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) govern the care and rights of mentally retarded persons. The finding includes: The facility failed to demonstrate protection of residents' rights to receive prompt and adequate medical attention [Title 7, Chapter 13, § 7-1305.05(g), formerly § 6-1965(g)], as follows: There was no evidence that the GHMRP ensured Resident #1 received an MRI as recommended by the neurologist. [See W322 & 331]	I 002	1002 In order to complete the order for MRI examination under sedation, an updated order would need to be obtained; the original order was dated 09/07/2006. A CT scan of Client #1's brain was performed on 10/21/06 as an alternative diagnostic test to evaluate the physiology of the brain. The CT scan revealed "no evidence of acute intracranial pathology". (See attached report). On 4.7.08 the Primary Care Physician deemed that Client #1's "altered mental state (AMS) was most likely metabolic" and "resolved-no further action". (See attached physician progress note).	10.21.06 4.7.08
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident's guardian, his or her next of kin if the resident has	I 374		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 374	<p>Continued From page 2</p> <p>no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that after medical services were secured, prompt notification of the resident's status would be made as soon as possible to the resident's guardian, his or her next of kin if the resident had no guardian, or the representative of the sponsoring agency, followed by written notice and documentation no later than forty-eight (48) hours after the incident, for Resident #1.</p> <p>The finding includes:</p> <p>Review of the facility's incident reports on December 3, 2008, beginning at 8:51 AM revealed the following:</p> <p>On October 4, 2008, staff reported that Resident #1 began to black out during her morning care in the facility's bathroom. The report revealed the resident was transported to the emergency room via ambulance. Review of the internal investigation on the aforementioned date revealed the resident was admitted to the hospital and diagnosed with syncope with an unknown etiology.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on December 3, 2008, at 11:01 AM revealed Resident #1 had a legal guardian that was involved in her care. At the time of the survey, however, the facility failed to provide</p>	I 374	<p>I 374</p> <p>The provider will in-service staff on appropriate notification in the event of changes in the individuals condition, serious illness, accident, death abuse or unauthorized absence. Training will include who to contact and appropriate documentation. Additionally, updated information on the next of kin/guardian will be provided on the individual's health passport.</p> <p>In addition, the IMC will review all reports to ensure all required parties are contacted in a timely manner.</p>	01/15/09	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 374	Continued From page 3 evidence that Resident #1's guardian had been notified as required.	I 374		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure timely treatment services and services designed to prevent deterioration or loss of functioning were conducted for one resident (Resident #1) included in the investigation. The finding includes: 1. The facility failed to provide evidence that Resident #1 received a recommended MRI and/or failed to provide evidence that the recommendation for the MRI was alternatively addressed. Review of the facility's incident reports on December 3, 2008, beginning at 8:51 AM revealed an incident involving Resident #1 dated October 4, 2008. According to the report, Resident #1 began to black out in the facility's bathroom during her morning care. The report further revealed the resident was transported to the emergency room via ambulance. Review of the internal investigation dated December 10, 2008, on December 3, 2008, revealed the resident was admitted to the hospital and	I 401	I 401 1. Reference response to 1002 Client #1 also underwent CT scan of the brain on 10/21/06 as further investigation of the diagnosis of altered mental state. The CT scan revealed "no evidence of acute intracranial pathology". (See attached report).	10.21.06

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 401	<p>Continued From page 4</p> <p>diagnosed with syncope (unknown etiology).</p> <p>Interview with the facility's Registered Nurse (RN) on December 3, 2008, was conducted to ascertain if Resident #1 had experienced any medical concerns prior to her admission to the hospital on October 4, 2008. According to the RN, Resident #1 had not experienced any medical problems before her admission to the hospital. Additionally, interview was conducted with a direct care staff on December 3, 2008 at 10:06 AM that further verified Resident #1's health status (no medical concerns) prior to her admission to the hospital.</p> <p>Continued interview with the RN and review of Resident #1's medical record on December 3, 2008, revealed a monthly nursing assessment dated September 27, 2008. Review of the nursing assessment revealed a page entitled "Systems Review/Risk Assessment." According to the Systems Review/Risk Assessment, a recommendation was made to follow-up with an "MRI of the brain and appointment with the neurologist." The RN indicated that when she started, in July 2008, she reviewed the client's medical record and discovered that the recommendation for Resident #1 to receive the MRI had not been completed. Additionally, the monthly nursing assessment (dated September 27, 2008) recommended to "follow-up on any outstanding appointments, continue with current plan of care and report any changes to the nurse."</p> <p>Further interview with the RN and review of the client's medical record revealed that Resident #1 had been seen initially by the neurologist on September 7, 2006. Review of the corresponding neurological consult revealed the resident was</p>	I 401			

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	<p>Continued From page 5</p> <p>referred to the specialist because she had experienced four seizure-like episodes. Further review of the consult revealed the direct care staff reported that the resident was also experiencing urinary incontinence and visual hallucinations. The neurologist recommended an EEG and an MRI of the brain to rule-out any structural lesions. Resident #1 was to return for a follow-up appointment after the completion of the MRI or in six weeks.</p> <p>On September 25, 2006, Resident #1 was scheduled for the MRI, however, the MRI was not completed because the Resident would not hold her head still. Additionally, review of the consult revealed a recommendation was made for the Resident to be sedated. Continued review of the client's record revealed the Resident was also seen by the neurologist on March 6, 2007. The consultation form revealed the MRI was again not completed because the resident was unable to remain still and follow instructions. At the time of the investigation, the facility failed to provide evidence that Resident #1 received the recommended MRI and/or failed to provide evidence that the recommendation for the MRI was alternatively addressed.</p> <p>2. The facility failed to provide evidence that verified Resident #1 received a recommended EEG.</p> <p>(Cross Refer number 1 above) Interview with the RN and review of Resident #1's medical record on December 3, 2008, revealed the resident had been seen by a neurologist on September 7, 2006. Review of the corresponding neurological consult revealed the resident was referred to the specialist because she had experienced four seizure-like episodes. Further review of the</p>	I 401	<p>I 401</p> <p>2. The EEG ordered by the neurologist was completed on 09/07/2006. The provider will ensure that specialty examinations and procedures are permanently maintained in the active medical record to ensure continuity of care. The provider will clearly indicate critical documents that are not to be purged from the active record.</p> <p>Purged records will be reviewed to ensure that critical documents remain in the active medical record. Nurses will receive additional training on the provider policy on maintenance of medical records, particularly as it pertains to purging medical records. (See attached)</p>	1/15/09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 6 consult revealed the direct care staff reported that the resident was also experiencing urinary incontinence and visual hallucinations. The neurologist recommended an EEG and an MRI of the brain to rule-out any structural lesions. Additional review of Resident #1's record on December 3, 2008, revealed a physician's quarterly progress note dated July 2, 2007. The progress note indicated that Resident #1 had an EEG in November 2006. The physician's progress note further documented that the EEG was completed. Interview with the RN on December 3, 2008, was conducted to ascertain information regarding the results of the EEG. The RN revealed the client's record had been purged. At the time of the investigation, the facility failed to provide evidence that verified the EEG had been conducted.	I 401		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to observe and protect the rights of a resident, in accordance with D.C. Law 2-137 (now Title 7, Chapter 13), and this chapter. The findings include: Section 7-1305.05 (g). [Formerly 6-1965] The	I 500		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	<p>Continued From page 7</p> <p>facility failed to ensure the resident's right to receive prompt and adequate medical attention, as evidenced below:</p> <p>1. Review of the facility's incident reports on December 3, 2008, beginning at 8:51 AM revealed an incident involving Resident #1 dated October 4, 2008. According to the report, Resident #1 began to black out in the facility's bathroom during her morning care. The report further revealed the resident was transported to the emergency room via ambulance. Review of the internal investigation dated December 10, 2008, on December 3, 2008, revealed the Resident was admitted to the hospital and diagnosed with syncope (unknown etiology).</p> <p>Interview with the facility's Registered Nurse (RN) on December 3, 2008, was conducted to ascertain if Resident #1 had experienced any medical concerns prior to her admission to the hospital on October 4, 2008. According to the RN, Resident #1 had not experienced any medical problems before her admission to the hospital. Additionally, interview was conducted with a direct care staff on December 3, 2008 at 10:06 AM that further verified Resident #1's health status (no medical concerns) prior to her admission to the hospital.</p> <p>Continued interview with the RN and review of Resident #1's medical record on December 3, 2008, revealed a monthly nursing assessment dated September 27, 2008. Review of the nursing assessment revealed a page entitled "Systems Review/Risk Assessment." According to the Systems Review/Risk Assessment, a recommendation was made to follow-up with an "MRI of the brain and appointment with the neurologist." The RN indicated that when she</p>	I 500	<p>I 500</p> <p>1. Reference response to 1002 Client #1 also underwent CT scan of the brain on 10/21/06 as further investigation of the diagnosis of altered mental state. The CT scan revealed "no evidence of acute intracranial pathology". (See attached report).</p>	10.21.06

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
1500	<p>Continued From page 8</p> <p>started, in July 2008, she reviewed the client's medical record and discovered that the recommendation for Resident #1 to receive the MRI had not been completed. Additionally, the monthly nursing assessment (dated September 27, 2008) recommended to "follow-up on any outstanding appointments, continue with current plan of care and report any changes to the nurse."</p> <p>Further interview with the RN and review of the resident's medical record revealed that Resident #1 had been seen initially by the neurologist on September 7, 2006. Review of the corresponding neurological consult revealed the resident was referred to the specialist because she had experienced four seizure-like episodes. Further review of the consult revealed the direct care staff reported that the resident was also experiencing urinary incontinence and visual hallucinations. The neurologist recommended an EEG and an MRI of the brain to rule-out any structural lesions. Resident #1 was to return for a follow-up appointment after the completion of the MRI or in six weeks.</p> <p>On September 25, 2006, Resident #1 was scheduled for the MRI, however, the MRI was not completed because the resident would not hold her head still. Additionally, review of the consult revealed a recommendation was made for the Resident to be sedated. Continued review of the resident's record revealed the Resident was also seen by the neurologist on March 6, 2007. The consultation form revealed the MRI was again not completed because the resident was unable to remain still and follow instructions. At the time of the investigation, the facility failed to provide evidence that Resident #1 received the recommended MRI and/or failed to provide</p>	1500			

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 500	<p>Continued From page 9</p> <p>evidence that the recommendation for the MRI was alternatively addressed.</p> <p>2. The facility failed to provide evidence that verified Resident #1 received a recommended EEG.</p> <p>(Cross Refer number 1 above) Interview with the RN and review of Resident #1's medical record on December 3, 2008, revealed the resident had been seen by a neurologist on September 7, 2006. Review of the corresponding neurological consult revealed the resident was referred to the specialist because she had experienced four seizure-like episodes. Further review of the consult revealed the direct care staff reported that the resident was also experiencing urinary incontinence and visual hallucinations. The neurologist recommended an EEG and an MRI of the brain to rule-out any structural lesions.</p> <p>Additional review of Resident #1's record on December 3, 2008, revealed a physician's quarterly progress note dated July 2, 2007. The progress note indicated that Resident #1 had an EEG in November 2006. The physician's progress note further documented that the EEG was completed. Interview with the RN on December 3, 2008, was conducted to ascertain information regarding the results of the EEG. The RN revealed the client's record had been purged. At the time of the investigation, the facility failed to provide evidence that verified the EEG had been conducted.</p> <p>(See also Federal Deficiency Report Citation W322 and W326)</p>	I 500	<p>I 500</p> <p>Continued from page 9</p> <p>2. Reference response to I 401</p>		